Where Would You Turn for Help? Older Adults' Awareness of Community Support Services*

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RÉSUMÉ

Les résultats précédents visant la sensibilisation des aînés aux services de soutien communautaires ne s'accordent pas et sont gâchés par l'acquiescence ou des allégations de partialité. Cela étant, la présente étude a utilisé une série de 12 scénarios pour décrire des situations courantes dans lesquelles se retrouvent les aînés pour qui des services de soutien communautaires seraient appropriés. Lors d'une entrevue téléphonique, nous avons lu à 1152 adultes âgés de 50 et plus une série de scénarios et nous leur avons demandé s'ils pouvaient indiquer un organisme communautaire vers lequel ils pourraient se tourner dans cette situation précise. Nous leur avons aussi interrogés sur leurs plus importantes sources de renseignements en matière de services de soutien communautaires. Les résultats indiquent que, si l'on a recours à une méthodologie par scénarios, la sensibilisation aux services de soutien communautaires était beaucoup plus faible qu'on ne l'avait d'abord pensé. Les plus importantes sources de renseignements sur les services de soutien communautaires comprenaient des sources de référence et des renseignements, l'annuaire téléphonique, les bureaux de médecins, et le bouche-à-oreille.

ABSTRACT

Previous findings on older adults' awareness of community support services (CSSs) have been inconsistent and marred by acquiescence or over-claiming bias. To address this issue, this study used a series of 12 vignettes to describe common situations faced by older adults for which CSSs might be appropriate. In telephone interviews, 1,152 adults aged 50 years and over were read a series of vignettes and asked if they were able to identify a community organization or agency that they may turn to in that situation. They were also asked about their most important sources of information about CSSs. The findings show that, using a vignette methodology, awareness of CSSs is much lower than previously thought. The most important sources of information about CSSs included information and referral sources, the telephone book, doctors' offices, and word of mouth.

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Many older adults experience a diminished ability to care for themselves and difficulty remaining independent in their own homes as they age. With the desire of older adults to age in place and the declining number and availability of children to provide care, Western industrial nations such as Canada have developed, in addition to home health services, a variety of community support services (CSSs) as an alternative to institutionalization. CSSs are delivered in the home or community to assist people coping with health or social problems to maintain the highest possible level of social functioning and quality of life. Examples of CSSs are food services, transportation services, day programs, volunteer visiting, and caregiver support services. CSSs, as defined here, do not include home health services.

Research shows that older adults have very low utilization rates of CSSs in Canada (Strain & Blandford, 2002). Access to CSSs is challenging because of a lack of awareness about CSSs, the multiplicity of small agencies providing community support, and the lack of a central access point. Furthermore, as the health care system becomes more complex, navigating the system becomes more difficult for older people, their families, and health care professionals.

Service awareness is an important topic because several studies have confirmed that lack of awareness of available services may lead to failure to recognize service needs or inability to access them (Benedito & Wister, 2005; Calsyn, Roades, & Klinkenberg, 1998; Cherry, 2002; Krout, 1985; Kushman & Freeman, 1986; Strain & Blandford, 2002; Wister, 1992). Furthermore, lack of awareness is a significant predictor of unmet need for services (Coulton & Frost, 1982). We currently lack valid and reliable information on older people's awareness of CSSs. Therefore, the purpose of this descriptive study was to measure older people's awareness of available CSSs and determine their sources of information about such services. In addition, this paper describes a methodology for gauging service awareness using vignettes or scenarios that describe common situations faced by older adults for which CSSs might be appropriate.

Existing studies of service awareness show use of forced-choice checklists for gauging awareness of services. The results of these checklists are expressed as percentages and sometimes summed to form a measure of the extent of knowledge. A survey of the literature on older adults' awareness of CSSs reveals inconsistent findings in the proportion of respondents who were aware of various community support services (31–78 per cent) (Calsyn, Roades, & Calsyn, 1992; Calsyn & Winter, 1999a; Ward, Sherman, & LaGory, 1984; Wister, 1992). In addition, the proportion of respondents who were aware of CSSs varied by the type of community service (Calsyn & Roades, 1993; Calsyn et al., 1998; Calsyn & Winter, 1999a, 2000; Chapleski, 1989; Kushman & Freeman, 1986; Salvage, Jones, & Vetter, 1988). However, many of these studies have combined in-home and health services in their summary measures of CSSs (Calsyn & Winter, 2000; Krout, 1985; Wister, 1992). Canadian data are sparse: Edmonton seniors indicated awareness of 54.3 per cent of ''ancillary health'' agencies (Snider, 1980a, 1980b); Quebec seniors were aware of 47 per cent of health and social services (West, Delisle, Simard, & Drouin, 1996); Waterloo seniors were aware of 67 per cent of home support services (Wister, 1992).

Based on the literature on service awareness, it might be argued that older adults are reasonably well informed about CSSs. As we have seen, however, in most service awareness studies respondents have been provided with lists of services or agency names and asked to state whether they were aware of each one. As Calsyn and Winter (1996b) have demonstrated, this methodology leads to over-claiming or acquiescence bias (the tendency of respondents to answer the question positively regardless of the content). In several studies researchers have provided older adults with a fictitious service or agency name,

and found that 20–30 per cent of respondents reported familiarity with the fictitious service (Calsyn & Roades, 1993; Calsyn, Roades, & Calsyn, 1992).

To address acquiescence bias in studies of service awareness, Calsyn, Kelemen, Jones, and Winter (2001) have recommended several solutions: Adjust the service awareness scores of the acquiescers, delete the acquiescers from the analysis, provide a warning that fictitious agencies are embedded in the list of real agencies, or use open-ended questions to solicit the names or types of agencies. However, deleting respondents who over-claim from the analysis might serve further to bias the study, given that some groups may be more likely to over-claim than others, such as those with lower levels of education, higher age, or certain ethnic groups (Calsyn, Burger, & Roades, 1996; Calsyn & Roades, 1993; Calsyn et al., 1998; Calsyn & Winter, 1999b, 2000). Some researchers have used open-ended questioning to avoid acquiescence bias. In these studies, respondents have been required to state the name of an agency or service that might address a specific problem (Moon & Evans-Campbell, 1999) or provide specific information about a named service to substantiate the claim of service awareness (Snider, 1980a, 1980b).

Researchers have found that older adults obtain information about CSSs from: formal sources such as service providers and physicians; informal sources such as family members, friends, and relatives; media sources such as television and radio; and print media such as newspapers, brochures, and telephone book yellow pages (Ehrlich, Carlson, & Bailey, 2003; Feldman, Oberlink, Simantov, & Gursen, 2004; Goodman, 1992; Sherman, Ward, & LaGory, 1984; Wicks, 2004). There is inconsistency in the literature about older adults' preferred sources of information. Formal information sources (physicians and service agencies) have been found to be most important in two studies (Ehrlich et al., 2003; Feldman et al., 2004) and relatively unimportant in two others, which found news media to be most important (Goodman, 1992; Ward et al., 1984). Authors of three studies have reported that informal sources, such as friends and relatives, are the third most important information source (Ehrlich et al., 2003; Goodman, 1992; Ward et al., 1984).

A review of the literature indicates to us that the primary source of awareness is an important predictor of overall awareness of CSSs. Silverstein (1984) examined the relationship of knowledge source to consideration of service use. She found that the informal network was as effective as the media in terms of overall knowledge, and that both of these were more effective than formal sources of information.

In summary, it is difficult to draw firm conclusions from the research literature on the awareness of CSSs because of: acquiescence bias; inconsistent findings across studies; and aggregation of CSSs with other services, particularly health services. Furthermore, there has been little rigorous research on the awareness of CSSs among older adults in Canada. In addition, the literature on the most important sources of information about CSSs is inconclusive.

This paper addresses three research questions[1]:

1 Do older people perceive a need for assistance when presented with a social or health problem for which CSSs might be appropriate?
2 Are older people aware of available CSSs?
3 Where do older people seek information about CSSs?

Method

Study Background

The issue of access to CSSs was identified as a research priority by community care agency representatives from Hamilton, Ontario, at two annual roundtable meetings. A working group of community care agency senior managers and front-line staff, representatives from planning agencies, and McMaster University researchers worked in partnership over a period of 18 months to define the research questions and develop the research methodology. Hamilton has a robust group of CSSs that work collaboratively (e.g., a coalition of non-profit CSSs meet monthly for planning purposes).

Based on population counts for census subdivisions in 2001, Hamilton was ranked the ninth largest city in Canada with a population of nearly 500,000 (Statistics Canada, 2001b). As a measure of the city's diversity, approximately one-quarter of the census metropolitan area of Hamilton is foreign-born (Statistics Canada, 2001c). This makes Hamilton the Canadian city with the third-highest proportion of foreign-born residents following Toronto (44%) and Vancouver (38%) (Statistics Canada, 2001c). Hamilton is an ''aging'' city; in 2001, 14.3 per cent of the Hamilton population was over the age of 65 years compared to Canada as a whole, which stood at 13 per cent (Statistics Canada, 2001a). Income levels are also slightly higher than in the rest of Canada.

Design and Procedure

We addressed the issue of acquiescence bias by using open-ended responses to vignettes or scenarios relevant to CSSs. The use of vignettes or scenarios is an established research methodology (Hughes & Huby, 2002; Spalding & Phillips, 2007; Urquhart, 1999); however, we found only one qualitative study that

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has used vignette methodology to study older adults' awareness of formal services (Schoenberg & Ravdal, 2000). Vignettes are short descriptions of hypothetical situations that closely approximate real-life decision-making or judgment-making situations. Respondents are read the vignettes and asked to respond to the hypothetical situation. The advantage of vignettes is that they are interesting to the respondent, they provide context, they can be used to address sensitive topics, and they depersonalize problems. They also avoid investigator bias, whereby the list of services is bounded by the investigators' awareness of services available.

To develop the vignettes used for this study, front-line service providers developed a series of 34 vignettes to describe realistic and familiar situations faced by older adults for which CSSs might be appropriate. After two pre-tests we reduced the set of vignettes to 12, which covered a broad range of CSSs available in the community. The vignettes have high face and content validity as they were developed by CSS providers and present common problems experienced by older adults. The pre-tests provided evidence that respondents were able to answer questions about four vignettes in an interview lasting approximately 25 minutes in length. The vignettes used in this study are found in Table 1.

Each vignette was meant to measure the awareness of CSSs relevant to one type of problem based on a "Yes" and "No" variable. Sample size was calculated to provide an estimation of the proportion of "Yes" for each vignette with a confidence interval of 95 per cent and maximum error of 0.05. Based on these criteria, a sample size of 384 was needed for each vignette. The 12 vignettes were divided into three groups, each containing four vignettes. With this design we estimated a total sample size of $3 \times 384 = 1{,}152$ for this study.

Awareness of CSSs was measured through a telephone survey of older adults in Hamilton. We contracted with a survey firm to complete the telephone interviews using their Computer-Assisted Dialing Information (CADI) system. Telephone interviews ($n = 1{,}152$) were completed in English within a six-week period beginning mid-February 2006. Residents aged 50 years and older were invited to participate in the study. We included middle-aged residents in the study for three reasons. First, it has

Table 1: Vignettes

Vignette Number	Panel	Vignette Title	Vignette
1	A	Grief Recovery	Your spouse died two years ago. You spend a lot of time watching game shows and soap operas. Your family expects you to get on with life. You wish you had someone to talk to.
2	A	Financial Insecurity	You are 72 years old, and your retirement savings are gone. You can't afford to live on your Old Age Security and Canada Pension Plan.
3	A	Parental Dementia	You are the main caregiver for your parent who has Alzheimer's disease. You have discovered that your mother has been taking more pills than she should.
4	A	Supporting Your Parents	The health of your parents is rapidly deteriorating. They are no longer able to cook, clean, or buy groceries. They want to stay in their own home.
5	B	Caregiver Burden	You are an only child of a parent with Alzheimer's disease. For years you have been bringing him meals, doing his laundry, and paying his bills. Your spouse is sick and now you have to help him/her too. You are feeling overwhelmed and frustrated.
6	B	Financial Abuse	Your son handles your banking and monitors your investments, since you are unable to leave the house. A recent bank statement shows a lot less money than you think should be there. You think your son is taking your retirement savings.
7	B	Leisure	You are single and recently retired. You have never had time to pursue any leisure activities. You are having trouble filling your time.
8	B	Chronic Disease and Safety	You have severe arthritis in your back and knees. You fell last week.
9	C	Caregiver Respite	Your mother, who lives with you, is very confused and can't be left alone. You want to keep her at home, but you have to go to work. The rest of the family are working and cannot help.
10	C	Maintaining Your Independence	You have poor health and are no longer able to do your shopping, housework, or yard work. Your family members are busy and you don't want to bother them.
11	C	Transportation	You have to go for chemotherapy at the hospital several times per week. Your family and friends are unable to help you. You cannot afford to take a taxi and are too weak to take public transit.
12	C	Spousal Alcohol Abuse	Your spouse has been retired for about a year. He/she has started to drink heavily.

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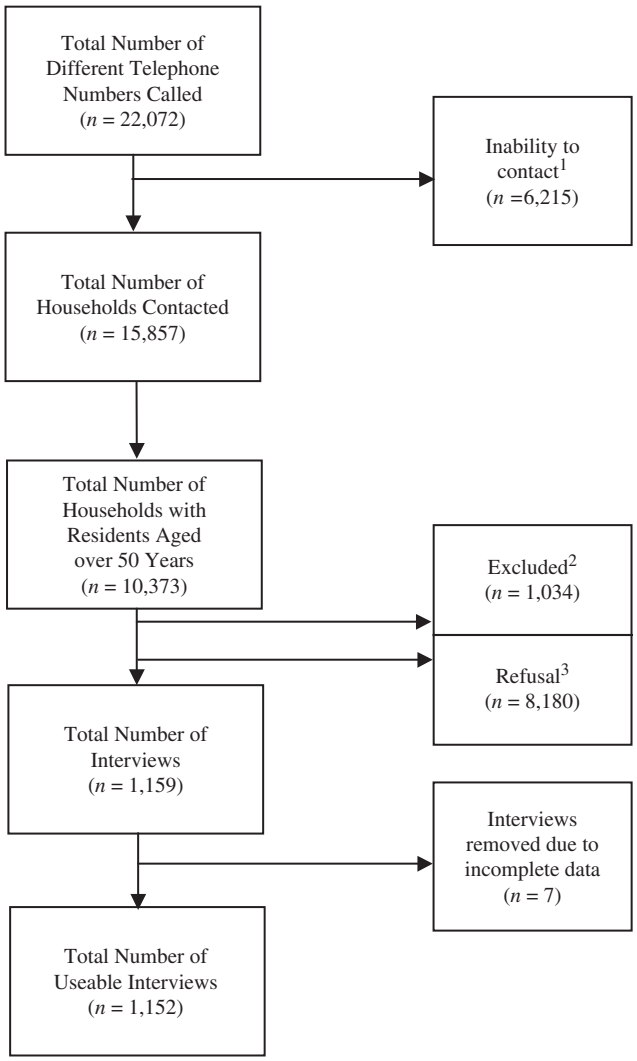
been well established that many middle-aged adults provide social support and care to their parents (Denton, 1997). Second, researchers have found that family members are an important source of information about CSSs (Goodman, 1992). Third, many middle-aged adults can be expected to need CSSs in the relatively near future. Therefore, it is important to know the level of awareness of CSSs held by middle-aged as well as older adults. The sample was obtained by randomly selecting telephone numbers from a list of telephone numbers for all residents in the City of Hamilton. Figure 1 illustrates that the response rate was 12.4 per cent (1,159/9,339) of eligible households that completed an interview.



1 Inability to contact due to the following reasons: Not in service, fax/modem, business number, busy, answering machine, no answer, and unresolved.

2 Excluded from total asked includes: language, illness/incapable.

3 Refusals include: household refusals, mid-survey refusal, respondent refusal.

Figure 1: Flow chart of response rates for telephone survey

Participants were each read one of three panels of four vignettes and asked to imagine themselves in the situation described in the vignettes. During the interview, people were asked: ''If you were in this situation, what would you do?'' and further, ''Can you name an organization or program in our community that you would turn to in that situation?'' As part of the telephone survey, we also collected demographic (i.e., age, gender, marital status, education, country of birth), economic (i.e., income), health (i.e., self-rated health, activity limitation), and social (i.e., social support, membership in voluntary organizations or associations) data about participants. Ethics approval was obtained through the McMaster University Research Ethics Board.

Interviewers were instructed to enter the responses as to what participants would do in the situations described in the vignettes as verbatim responses. These responses were then coded by the survey firm's coders, working in concert with the researchers, into 150 different types of responses. The data were provided to the researchers in the form of an SPSS file. These were re-coded into 20 meaningful categories for the purpose of analysis (see Table 2). This process was carried out by the authors in concert with several rounds of peer checking among our community partners until we had consensus that the reduction from 150 to 20 categories was meaningful and accurate.

Recognizing that reliance on being able to respond in English may have been a problem for our telephone

Table 2: Categories of participant responses to vignettes

1	Community support services
2	Spouse
3	Son/daughter
4	Friends and neighbours
5	Relatives
6	Physician
7	Emergency
8	Clinics/hospitals
9	Other health professionals
10	Non-health professionals
11	Pastor/clergy/faith community
12	Social and recreation services
13	Nothing
14	Home health services
15	Long-term care/residential care
16	Self-help/personal strategy
17	Government
18	Information and referral services
19	Disease-specific agencies
20	Community Care Access Centre (CCAC)

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survey, we also conducted five focus groups with Spanish (2 groups), Arabic, Vietnamese, and Caribbean immigrants to learn about their awareness of CSSs. Participants in the focus groups had very little awareness of CSSs (with the exception of the Caribbean immigrants). Responding to the vignette scenarios, most focus-group participants acknowledged that they would rely on their family or faith groups. These results will be reported in detail elsewhere.

Results

The study participants represented a wide cross-section of older adults in Hamilton. Tables 3 and 4 present the demographic profile of the study respondents. These tables show that over two-thirds of study participants were female (71%). In terms of age, 61 per cent were over the age of 60 years. Most (63%) participants were married or in a common-law relationship, with 19 per cent being widowed, 12 per cent divorced or separated, and 6 per cent single or never married. Household income varied across four categories, with the most frequent category (39%) being $60,001 or over. In terms of education, about half of study participants had high-school education or less (46%), 25 per cent had a trade, non-university certificate or community college, and 27 per cent had university education. Over half of the study participants (54%) rated their health as very good or excellent, 28 per cent rated it as good and 15 per cent rated it as fair or poor. Most participants were born in Canada (71%). Comparisons to data on Hamilton from the Canadian Census show that our sample is disproportionately female, Canadian born, and has English as a first language. More respondents have higher levels of education than is true for residents of Hamilton.

After being read each vignette, participants were asked, ''If you were in this situation, what would you do?'' As shown in Figure 2, while this varied by vignette, approximately 93 per cent said that they would seek some kind of help. We prompted with ''Anything else?'' up to four times for this question, in order to establish multiple sources of assistance. As noted previously, 20 types of help were named by participants, including self help, assistance from family and friends, physicians, CSSs, and pastors/clergy.

We addressed the question of to what extent older people are aware of available CSSs in two ways. We calculated the percentage of study participants who identified a CSS as their first response. If the study participant did not name a CSS to this first question, we further asked, ''Can you name an organization or program in our community that you would turn to in that situation?'' Again we used up to four prompts until a CSS was named. The percentage of respondents who answered a CSS at any point during the two questions was then calculated. These results are shown in Figure 3.

There is a distinction in the literature between service awareness and knowledge. Awareness is a general understanding that a service exists, but no specific

Table 3: Basic demographics of the sample[a]

	Males, Aged over 50 Years		Females, Aged over 50 Years		Combined Total , Aged over 50 Years (Males + Females)	
Demographic Variable	Sample Percentage ($n = 331$)	Hamilton Population Percentage ($n = 106,160$)	Sample Percentage ($n = 821$)	Hamilton Population Percentage ($n = 125,575$)	Sample Percentage ($n = 1,152$)	Hamilton Population Percentage ($n = 231,750$)
Age						
50–54	19.6	22.4	20.3	20.2	20.1	21.2
55–59	21.1	20.1	18.0	18.2	18.9	19.0
60–64	17.2	15.5	17.7	14.0	17.5	14.7
65–69	13.0	12.3	13.2	11.6	13.1	11.9
70–74	10.0	10.7	10.2	10.7	10.2	10.7
75–79	9.7	9.1	12.3	10.1	11.5	9.6
80–84	4.8	6.2	5.2	8.4	5.1	7.4
85 or over	4.5	3.7	3.0	6.8	3.5	5.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Sex						
Male	–	–	–	–	28.7	45.8
Female	–	–	–	–	71.3	54.2

[a] Comparisons made with available 2006 census data from Statistics Canada

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Table 4: Basic demographics of the sample[a]

Demographic Variable	Males, Aged over 50 Years		Females, Aged over 50 Years		Combined Total, Aged over 50 Years (Males + Females)	
	Sample Percentage ($n = 331$)	Hamilton Population Percentage ($n = 90,817$)	Sample Percentage ($n = 821$)	Hamilton Population Percentage ($n = 104,795$)	Sample Percentage ($n = 1,152$)	Hamilton Population Percentage ($n = 195,612$)
Education						
Less than High School	3.9	17.2	5.4	18.9	4.9	18.1
Some – All of High School	41.7	31.7	41.5	42.0	41.6	37.2
Trades, Non-University Certificate, Community College	21.5	28.3	26.7	24.4	25.2	26.2
University or Higher	31.4	22.9	25.8	14.8	27.4	18.5
Country of Birth						
Born in Canada	71.6	59.4	71.3	58.0	71.4	58.7
Foreign Born	27.5	40.6	27.9	42.0	27.8	41.3
Language						
English	94.3	84.9	94.8	84.3	94.6	84.6
French	0.9	0.6	0.5	0.6	0.6	0.6
Other	4.8	14.5	4.8	15.1	4.8	14.8
Marital Status						
Married, Common-Law	71.6	76.9	59.6	58.0	63.1	66.8
Widowed	12.4	6.5	21.9	25.4	19.2	16.7
Divorced, Separated	10.3	10.7	12.1	12.3	11.6	11.5
Single, Never Married	5.7	5.9	6.3	4.3	6.5	5.0
Household Income ($)[b]						
$20,000 or less	11.2	7.9	16.7	16.9	15.0	12.7
$20,001–40,000	26.6	23.1	28.1	25.0	27.6	24.1
$40,001–60,000	16.5	19.1	19.6	18.6	18.6	18.9
$60,001 or over	45.7	49.7	35.6	39.3	38.7	44.2
Self-Reported Health						
Excellent	20.6	–	21.1	–	20.9	–
Very Good	34.2	–	33.0	–	33.3	–
Good	25.7	–	29.1	–	28.1	–
Fair	13.0	–	12.5	–	12.7	–
Poor	6.4	–	3.8	–	4.5	–

[a] Comparisons made with 2001 census data from Statistics Canada (2006 data unavailable at time of creation).
[b] The number of study responses to the household-income question were 278 (males), 634 (females), 912 (both males and females).

information that would be needed to access a service. Knowledge is knowing the name of an agency or program, how to contact it, or where it is located (Krout, 1985; Kushman & Freeman, 1986). Of those participants identifying a CSS in this study, the vast majority were able to name an agency. A minority were only able to identify a type of service. Both response types are included in our measure of awareness of CSS.

Furthermore, respondents may be able to name an agency, but it *could be* the wrong agency for the task at issue. This in fact was the case for a small minority of participants. This issue was discussed with our advisory committee of community service providers and we reasoned that if a call was made to any CSS, even one that did not provide the relevant service, then it was likely that a referral would be made to the appropriate service provider, resulting in access to services.

The bottom section of each bar on the graph in Figure 3 shows the percentage of respondents who named a CSS as their first response to the question "What would you do?" in response to the situation described by the vignette. The top or lighter section of each bar shows the percentage of respondents who named a CSS at any later point during the questioning about the vignette. Awareness of CSSs was limited and varied by the situation described, and ranged from a low of one per cent to a high of 41 per cent, with an average of 21 per cent. Respondents were most likely to be aware of services to assist with caregiver burden and transportation services.

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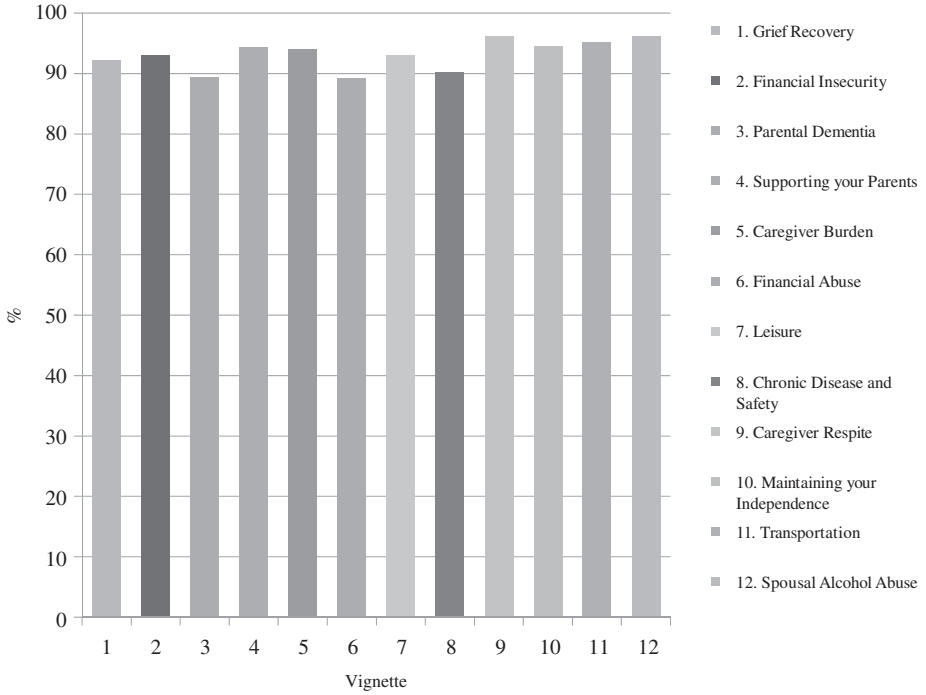

Figure 2: Percentage of respondents who would seek help by vignette; (*N*=384 for each vignette)

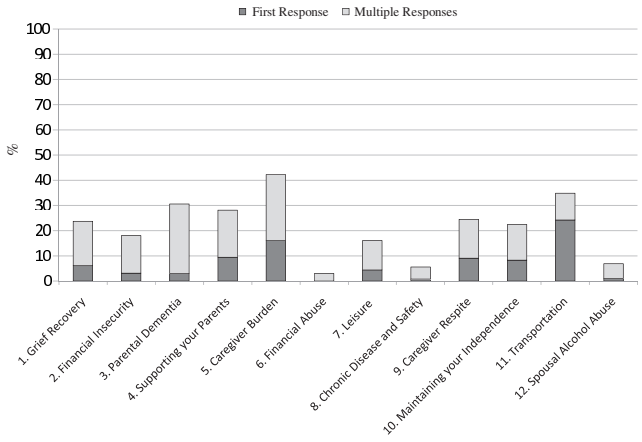

Figure 3: Percentage of respondents who answered CSSs by vignette by first and multiple responses (*N*=384 for each vignette)

Awareness was also higher for CSSs providing assistance with parental dementia, supporting parents, grief recovery, maintaining independence, and financial insecurity. There was very little awareness of CSSs available to assist people with finding leisure activities, spousal alcohol abuse, chronic disease and safety, and financial abuse.

Overall, 86 per cent were able to provide information on where they would seek information about CSSs. As shown in Figure 4, about one-quarter of older people would seek information about CSSs from information and referral services, the telephone book, a doctor's office, and from informal sources such as discussions with friends, neighbours, and family members. One-sixth would seek information on the Internet. Less frequently mentioned sources of information (5–10%) included social and recreation centres, hospitals and clinics, and the Community Care Access Centre (CCAC)—a one-stop access centre for home health care services that also offers information and referral services.

Discussion

This study's results make an important contribution to the literature on older people's awareness of CSSs. Most studies on service awareness are more than a decade old and combine CSSs and health services (Calsyn & Roades, 1993; Calsyn et al., 1998; Calsyn & Winter, 1999a; Chapleski, 1989; Kushman & Freeman, 1986; Salvage et al., 1988), whereas we focused only on CSSs. Furthermore, there are very few Canadian studies on service awareness (Snider, 1980a, 1980b; Wister, 1992). Most literature focuses on service utilization, although two studies have included service awareness as a determinant of service use (Strain & Blandford, 2002; Wister, 1992).

By using a vignette methodology, over-claiming or acquiescence bias was avoided. The percentage of participants with awareness of CSSs ranged from one

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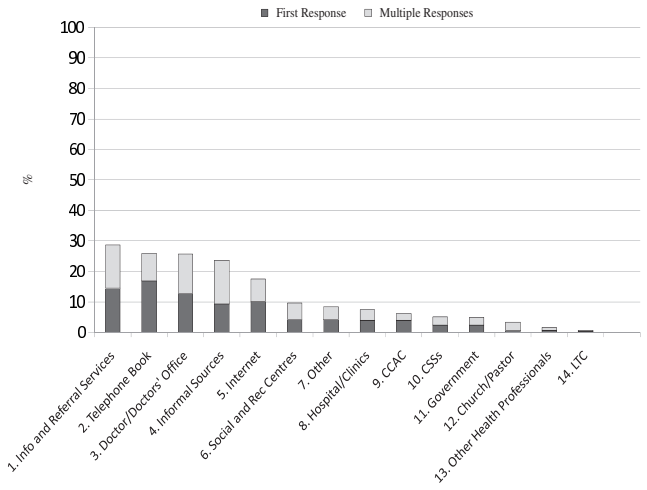

Figure 4: Sources of information about CSSs; first response and multiple responses

Note: *Information and Referral Services* includes Newspaper/TV/Radio/Magazines/Media/Mail/The Red Book (directory of services)/Library/University and College; *Informal Sources* includes Friends/ Neighbours/Work-related friends/Mother/Daughter-Son-In-Law/Word of Mouth/Other Undefined Relative/ Daughter/Child/Mother-Father-Parent-In-Law/Spouse/ Son/Sister/Sister-Brother-In-Law/Father

to 41 per cent, depending on the type of situation described. The proportion of older adults found to be aware of CSSs was much lower than the findings of many other studies, many of which suffered from acquiescence bias (Calsyn & Roades, 1993; Calsyn et al., 1998; Calsyn & Winter, 1999b, 2000; Chapleski, 1989; Kushman & Freeman, 1986; Salvage et al., 1988; Wister, 1992).

The use of vignette methodology also served to decrease investigator bias, where the investigator checklist of services is limited by his/her breadth of awareness. The vignettes were developed from hypothetical but realistic and relevant situations by expert practitioners (Urquhart, 1999), thus providing high face and content validity to the findings. Participants enjoyed the depersonalized vignette format, which encouraged them to think beyond their own situations. Some of the topics were sensitive (e.g., financial abuse, alcohol abuse) and we were able to ask these questions in a non-threatening way (Schoenberg & Ravdal, 2000).

Consistent with what we found in the literature (Calsyn & Roades, 1993; Calsyn et al., 1998; Calsyn & Winter, 1999a, 2000; Chapleski, 1989; Kushman & Freeman, 1986; Salvage et al., 1988), we found that the level of awareness about CSSs varied by the type of service. Participants were most likely to be aware of transportation services, services for older people with dementia, and home support services. There was very little awareness of CSSs that are available to assist people who are socially isolated and lonely, who are having financial difficulties, or who suffer from financial or alcohol abuse.

Researchers indicate that older adults wish to ''age in place'' (Chappell, McDonald, & Stones, 2008). If they are to maintain their independence and live in their own homes for as long as possible then it is imperative that they have awareness about the services that are available to assist them with health or social problems. Our study findings showed that participants are most likely to use an indirect route to seek information about CSSs, including the telephone book, information and referral services (including newspapers, media, and the library), doctors and doctors' offices, informal sources of information (i.e., family, friends, and neighbours), the Internet, and various other sources. These findings are consistent with other research that found formal information sources (e.g., physicians and service agencies) to be important (Ehrlich et al., 2003; Feldman et al., 2004), as well as research that found media to be important information sources (Goodman, 1992; Ward et al., 1984). Only about 10 per cent of participants indicated that they would obtain information about CSSs from the CCAC, a one-stop access centre for provincially funded in-home health and personal care supports, as well as information and referral services.

While the telephone book was the most frequently mentioned source of information about CSSs, an examination of seniors' services in the *Yellow Pages* revealed that only a very few CSSs were listed, and that the local CCAC did not list its phone number under that section in the *Yellow Pages* nor under ''seniors'' in the blue pages (government pages). While doctors' offices were identified as an important source of information about CSSs, physicians are generally not knowledgeable about CSSs (Fortinsky, 1998; Henninger, Henninger, Morse, & Zweigenhaft, 1986).

The results of this study are limited by several factors. First, using a random telephone survey technique resulted in a low response rate, as has been demonstrated in other studies of access to services (Calsyn & Winter, 2000). Agreement to participate in a telephone interview is getting more and more difficult to achieve with the constant barrage of telemarketing and the use of caller ID and telephone-answering services. While there was a wide range of participants, the sample was over-represented by participants who were female, had English as a first language, were

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Canadian-born, and had higher levels of education. Given that research has shown that women and those with higher levels of education have higher levels of service awareness (Calsyn & Roades, 1993; Calsyn et al., 1998), we speculate that the levels of awareness of CSSs found in this study are in fact inflated. Furthermore, access to services may be further complicated for those whose language is other than English or French, since most services are accessible in only the two official languages. Despite study limitations, findings do show that there is an unmet need for CSSs as suggested by our findings of high levels of perceived need, but low levels of awareness of available CSSs. Lack of awareness of CSSs is a serious problem that needs to be addressed so that older adults may utilize the CSSs available to assist them. If awareness of CSSs increased significantly among older adults there would, however, be a corresponding need for additional capacity in CSSs.

The findings presented here are descriptive, indicating the level of awareness for CSSs. Further investigation into the social determinants of awareness of CSSs is merited. In addition, more detailed analysis of where people with specific problems – such as coping with dementia, financial difficulties, maintaining independence, and substance abuse – turn to for help needs to be done. Many respondents indicated that they would turn to their family physician for information about where to seek assistance. Research that documents the knowledge of CSSs held by physicians or the staff in their offices and their referral patterns would also be beneficial in order to target knowledge dissemination strategies.

While this research was set in the City of Hamilton, accessibility to services is an issue of concern across the province and, indeed, across Canada, since knowledge of CSSs is key to utilization of services. The results of this research can inform policy at all levels of government and will help agencies to identify targets for service awareness and education strategies. In terms of policy and practice issues, awareness-translation activities need to be implemented to increase the level of awareness among older adults and their caregivers regarding the CSSs available to assist older adults with health and social problems. In particular, awareness of services to assist people who are socially isolated and lonely, who are having financial difficulties, or who suffer from financial or alcohol abuse should be targeted.

Some communities in Ontario are introducing 211 as a telephone information service, and this may be a promising solution to the lack of awareness of CSSs (www.211canada.ca). Furthermore, there may be a role for social workers, care managers, or nurse practitioners in community health practices in making referrals or providing information about CSSs to patients. Since many older adults would seek assistance from their informal networks, strengthening informal networks is an important strategy to improve access to services. This may include workshops for or presentations to middle-aged adults, seminars through places of employment, and developing interactive Internet sites. There are also opportunities to link information to activities that are frequented by seniors (e.g., in senior centres and community health centres). Many immigrants have low incomes and many do not speak English. Settlement services are a magnet for recent immigrants and provide access to the social networks of immigrant communities. Information about CSSs could be presented through pamphlets and informal meetings in the languages of the different immigrant groups (Lillie, 2008).

Note

1 This is an initial study in a planned program of research dealing with access to CSSs. In a subsequent paper, we will examine the demographic, personal, and social characteristics that are associated with awareness of and information sources for CSSs.

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